National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

Using the PTSD Checklist for *DSM-IV* (PCL)

NOTE:

The PCL was revised in accordance with *DSM-5* (PCL-5). The information in this handout describes the PCL for *DSM-IV*. Several important revisions were made to the PCL-5, including changes to existing symptoms and the addition of three new symptoms of PTSD. The self-report rating scale for PCL-5 was also changed to 0-4. Therefore, the change in the rating scale combined with the increase from 17 to 20 items means that **PCL-5 scores are not compatible with PCL for *DSM-IV* scores and cannot be used interchangeably.**

When further psychometric work on the PCL-5 is completed, a new handout will be made available. Preliminary validation work is sufficient to make initial cut-point suggestions, but this information may be subject to change. Overall, optimal PCL-5 cut-points appear to be 11-14 points lower than for PCL for *DSM-IV* cut-points, with closer to an 11-point different for more stringent cutoffs and closer to a 14-point difference for more lenient cutoffs. A PCL-5 cut-point of 33 appears to be a reasonable value to propose until further psychometric work is available.

What is the PCL for *DSM-IV*?

The PCL is a 17-item self-report measure reflecting *DSM-IV* symptoms of PTSD. The PCL has a variety of purposes, including:

- screening individuals for PTSD
- aiding in diagnostic assessment of PTSD
- monitoring change in PTSD symptoms

There are three versions of the PCL for *DSM-IV*:

1. The **PCL-M** (military) asks about symptoms in response to "stressful military experiences." It is often used with active service members and Veterans.
2. The **PCL-C** (civilian) asks about symptoms in relation to generic "stressful experiences" and can be used with any population. This version simplifies assessment based on multiple traumas because symptom endorsements are not attributed to a specific event. In many circumstances it is advisable to also assess traumatic event exposure to ensure that a respondent has experienced at least on event that meets *DSM-IV* Criterion A.
3. The **PCL-S** (specific) asks about symptoms in relation to an identified "stressful experience." The PCL-S aims to link symptom endorsements to a specified event. Similar to the PCL-C, it is optimal to assess traumatic event exposure to ensure that the index event meets PTSD Criterion A. Respondents also can be instructed to complete the PCL-S in reference to a specified event or event type (e.g., assault, disaster, or accident).

How is the PCL for *DSM-IV* administered and scored?

The PCL is a self-report measure that can be read by respondents themselves or read to them either in person or over the telephone. It can be completed in approximately 5-10 minutes.

The PCL for *DSM-IV* can be scored in different ways:

- **A total symptom severity score** (range = 17-85) can be obtained by summing the scores from each of the 17 items that have response options ranging from 1 "Not at all" to 5 "Extremely."
- The gold standard for diagnosing PTSD is a structured clinical interview such as the Clinician-Administered PTSD Scale (CAPS). When necessary, the PCL can be scored to provide a presumptive diagnosis. This has been done in three ways:

1. determine whether an individual meets *DSM-IV* symptom criteria as defined by at least 1 B item (questions 1-5), 3 C items (questions 6-12), and at least 2 D items (questions 13-17). Symptoms rated as "Moderately" or above (responses 3 through 5 on individual items) are counted as present.
2. determine whether the total severity score exceeds a given normative threshold (see Table 1).
3. combine methods (1) and (2) to ensure that an individual meets both the symptom pattern and severity threshold.

Choosing a cut-point score

Factors to be considered when choosing a PCL cut-point score include:

- **The goal of the assessment:** A lower cut-point is considered when screening for PTSD or when it is desirable to maximize detection of possible cases. A higher cut-point is considered when informing diagnosis or to minimize false positives.
- **The prevalence of PTSD in the target setting:** Generally, the lower the prevalence of PTSD in a given setting, the lower the optimal cut-point. In settings with expected high rates of PTSD, such as specialty mental health clinics, consider a higher cut-point. In settings with expected low rates of PTSD, such as primary care clinics or circumstances in which patients are reluctant to disclose mental health problems, consider a lower cut-point.

Below are suggested cut-point ranges based on prevalence and setting characteristics. There is no absolute method for determining the correct cut-point on the PCL. If you know the prevalence of PTSD in your target population, use column 1 to find the suggested PCL cut-point (column 3). If you do not know the prevalence in your population, you can choose a cut-point based on the type of setting (column 2) in which you are working. Consider scores on the low end of the range if the goal is to screen for PTSD. Consider scores on the high end of the range if the goal is to aid in diagnosis of PTSD.

Table 1. Suggested PCL cut-point scores

Estimated Prevalence of PTSD	Typical Setting	Suggested PCL Cut-Point Scores
15% or Below	e.g. civilian primary care, Department of Defense screening, or general population samples	30-35
16-39%	e.g. specialized medical clinics (such as TBI or pain) or VA primary care	36-44
40% or Above	e.g. VA or civilian specialty mental health clinics	45-50

Note. These recommendations are general and approximate, and are not intended to be used for legal or policy purposes. Research is needed to establish optimal cut-point scores for a specific application.

Measuring change

Good clinical care involves monitoring patient progress. Evidence suggests that a 5-10 point change is reliable (i.e not due to chance) and a 10-20 point change is clinically meaningful (Monson et al., 2008). Therefore, we recommend using 5 points as a minimum threshold for determining whether an individual has responded to treatment and 10 points as a minimum threshold for determining whether the improvement is clinically meaningful.

Studies that informed our recommendations

1. Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD checklist (PCL). *Behavioral Research & Therapy, 34*, 669-673.
2. Bliese, P. D., Wright, K. M., Adler, A. B., Cabrera, O., Castrol, C. A., & Hoge, C. W. (2008). Validating the primary care posttraumatic stress disorder screen and the posttraumatic stress disorder checklist with soldiers returning from combat. *Journal of Consulting and Clinical Psychology, 76*, 272-281.
3. Dobie, D. J., Kivlahan, D. R., Maynard, C., Bush, K. R., McFall, M. E., Epler, A. J., & Bradley, K. A. (2002). Screening for post-traumatic stress disorder in female Veteran's Affairs patients: Validation of the PTSD checklist. *General Hospital Psychiatry, 24(6)*, 367-374.
4. Freedy, J. R., Steenkamp, M. M., Magruder, K. M., Yeager, D. E., Zoller, J. S., Hueston, W. J., & Carek, P. J. (2010). Post-traumatic stress disorder screening test performance in civilian primary care. *Family Practice*.
5. Harrington, T., & Newman, E. (2007). The psychometric utility of two self-report measures of PTSD among women substance users. *Addictive Behaviors, 32*, 2788-2798.
6. Keen, S. M., Kutter, C. J., Niles, B. L., & Krinsley, K. E. (2008). Psychometric properties of PTSD checklist in sample of male Veterans. *Journal of Rehabilitation Research and Development, 45*, 465-474. doi:10.1682/JRRD.2007.09.0138
7. Monson, C. M., Gradus, J. L., Young-Xu, Y., Schnurr, P. P., Price, J. L., & Schumm, J. A. (2008). Change in post-traumatic stress disorder symptoms: Do clinicians and patients agree? *Psychological Assessment, 20*, 131-138. doi:10.1037/1040-3590.20.2.131
8. Kimerling, R., Prins, A., Yeager, D. E., & Magruder, K. M. (2010, November). An interval approach to screening for PTSD in primary care. Poster presented at the 44th annual conference of the Association for Behavioral and Cognitive Therapies, San Francisco, CA.
9. Sherman, J. J., Carlson, C., Wilson, J. F., Okeson, J., & McCubbin, J. A. (2005). Posttraumatic stress disorder among patients with orofacial pain. *Journal of Orofacial Pain, 19*, 309-317.
10. Walker, E. A., Newman, E., Dobie, D. J., Ciechanowski, P., & Katon, W. (2002). Validation of the PTSD checklist in an HMO sample of women. *General Hospital Psychiatry, 24*, 375-380. doi:10.1016/ S0163-8343(02)00203-7
11. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). *The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility.* Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX. NOTE: Due to some confusion over versions of the PCL, some of the published papers state that the PCL-C was used in this study, but the authors have confirmed that the PCL-S was the version actually used.
12. Yeager, D. E., Magruder, K. M., Knapp, R. G., Nicholas, J. S., & Frueh, B. C. (2007). Performance characteristics of the posttraumatic stress disorder checklist and SPAN in Veterans Affairs primary care settings. *General Hospital Psychiatry, 29*, 294-301. doi:10.1016/j.genhosppsych.2007.03.004